LOW INCOME HEALTH PROGRAM

RIGHTS AND RESPONSIBILITIES OF APPLICANTS

I am applying for the Low Income Health Program (LIHP) from the County of San Diego for myself or for _____ _____.

I fully understand I have the following Rights and Responsibilities as part of my application for, and receipt of LIHP.

RIGHTS - I HAVE THE RIGHT TO:

1. Apply for LIHP and to be told **IN WRITING** whether or not I qualify.
2. Be notified of an action taken to discontinue my LIHP eligibility at least ten days prior to the first of the month in which the action becomes effective.
3. Request an appeal if I do not agree with the LIHP eligibility decision(s), or LIHP denial of health services. I must request the review within the timeframe stated on my notice.
4. File a grievance if I am dissatisfied about other matters, as described in the LIHP "Your Grievance and Appeal Rights" document. I must request the grievance within the timeframe stated on the LIHP "Your Grievance and Appeal Rights" document.
5. Talk to LIHP staff that can help me with my questions, problems, complaints, and or file a grievance.
6. Be treated fairly and equally whatever my race, color, religion, national origin, sex, age or political beliefs.
7. Free language, visual and hearing impairment assistance.
8. Privacy and to have all information that I give to the LIHP kept in confidence, except as required or allowed by law.
9. Choose my medical provider and Primary Care Physician within the limits of the program.
10. Reasonable access to health care services through the LIHP.
11. Be treated with courtesy and respect, to receive clear explanations of my health problems and to participate in decisions about treatment of my health problems.
12. Request or refuse medical treatment.
13. Request a second opinion if I do not agree with the medical care or the treatment plan prescribed for me by my medical care provider.
14. Information about the right to have an Advance Health Care Directive. If I already have one and wish to bring a copy, my provider will add it in my medical record.

RESPONSIBILITIES - I HAVE THE RESPONSIBILITY TO:

1. Give accurate information to the LIHP Representative.
2. Report to the LIHP Representative any changes that occur within 10 days of the change by calling 1-888-553-5552. These changes include, but are not limited to, the following:
   - ✓ My income or a family member's income from any source changes, or our employment situation changes.
   - ✓ I plan to move or change my mailing address.
   - ✓ A family member moves in or out of my home.
   - ✓ I receive, transfer, give away or sell any item of real or personal property.
   - ✓ I or a member of my family become pregnant or become so physically or mentally ill that we cannot work.
   - ✓ I or a member of my family apply for or become eligible to financial benefits from a State, County or Federal Program. Examples include, but not limited to, Social Security benefits, Veterans Administration benefits, CalWORKs, or Disability Compensation.
   - ✓ I have filed an appeal with the Social Security Administration relating to the denial of my disability benefits.
3. Report to the LIHP Representative and use any health care coverage, including insurance, I carry or am entitled to use.

HHSA: LIHP-15 (12/11) Rights & Responsibilities
Distribution: ORIGINAL TO APPLICANT; COPY TO CASE RECORD

County of San Diego
Health and Human Services Agency

LOW INCOME HEALTH PROGRAM

RIGHTS AND RESPONSIBILITIES OF APPLICANTS

4. Report to the LIHP Representative when LIHP has provided or will provide health care services for an accident or injury which may be covered by 1) my own insurance company or 2) from a third party when I file a lawsuit or lawsuit is filed on my behalf, and the action results in a judgment awarded to me.
5. Repay LIHP from third party recovery, including lawsuits.
6. Calling my primary care provider for medical advice FIRST, except in an emergency.
7. Arriving on time for my scheduled appointments.
8. Letting my medical care providers know if I do not understand my treatment plan or what is expected of me, and if I agree to the treatment recommendations, following my medical care providers' instructions.
9. Giving accurate and complete information about my present condition and past illnesses to my medical care providers.
10. Treating providers and LIHP staff with respect and dignity.
11. Cooperate with doctors and nurses in receiving LIHP health services. This includes receiving all health services through the LIHP authorized medical provider, keeping doctor's appointments, and following all treatment plans and instructions given to me by my health care provider.

UNDERSTAND - I FULLY UNDERSTAND THAT:

1. Enrollment discrimination and disenrollment discrimination is prohibited.
2. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which I make the request.
3. If I am potentially eligible for Medi-Cal, I must apply for and fully cooperate with the Medi-Cal process for full scope coverage, and accept coverage if eligible. Failure to do so may result in loss of current or future LIHP eligibility.
4. Failure to provide necessary information, report changes promptly, or deliberately giving false information can result in denial or overpayment of LIHP benefits and I may be prosecuted for fraud. I may also be responsible to repay LIHP for benefits I received for which I was not eligible.
5. The facts I give may be checked against facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
6. Although every effort is made to make all eligibility determinations error free, on occasion, a subsequent quality review of an eligibility determination will reveal that an error was made in granting LIHP benefits. I understand that there is no right to retain LIHP benefits granted in error. Upon notification by County, LIHP benefits granted in error must be returned to the County.

I hereby state that I have reviewed the information on this form and that I fully understand my RIGHTS AND RESPONSIBILITIES under the LIHP and agree to comply with LIHP requirements.

Applicant or Representative _____ Date _____